

Abstracts

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therapy, prior authorization, not in formulary) between January 1, 2005 to December 31, 2006 but who subsequently filled an SGA or conventional antipsychotic within six months of the rejected claim, formed the case group (n = 328). Newly initiated antipsychotic users who were in health plans with an open formulary and thus did not experience rejection of an SGA claim formed the control group (n = 1097). All patients were followed up for 13 months. Cox regression models were used to estimate the effect of having rejected claims on all-cause discontinuation of the index drug, defined as discontinuation, add-on or switch. The model controlled for age, sex, co-morbidities, geographic locations, index drug, prescription and co-payment. **RESULTS:** Reasons for rejected claims were distributed as follows: 1) drug not on formulary (72.9%); 2) required prior authorization (19.5%); and 3) required step therapy (7.6%). Median time to discontinuation was 120 days for the case group and 127 days for the control group. The adjusted hazard for discontinuation of the index drug (HR = 1.29, 95% CI: 1.08–1.53) was significantly higher for patients with rejected initial SGA claims compared to controls. Co-payments ranging from \$20 to \$39 were associated with lower discontinuation compared with copayment ranging from \$0 to \$4 (HR = 0.75, 95% CI: 0.60–0.93). **CONCLUSIONS:** New antipsychotic users with rejected initial SGA claims due to formulary restrictions were more likely to discontinue their antipsychotic drugs compared to users who did not face such restrictions.

PMH45

THE ASSOCIATION OF COPAY BURDEN AND MEDICATION ADHERENCE AMONG PATIENTS WITH SCHIZOPHRENIA

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OBJECTIVES: To assess the association between self-perceived copay burden and medication adherence among patients with schizophrenia. **METHODS:** Data were collected from December 2007 to February 2008 from a web-based consumer panel. Adults (age 18+) self-reporting a diagnosis of schizophrenia were invited to participate in the study through self-reported questionnaires on both the internet and through 43 interview facilities across the US. Inclusion criteria for analysis were: current use of an SGA, and no exposure to clozapine or a depot formulation antipsychotic. Adherence was assessed using the MMAS, with general adherence defined as MMAS < 2, and complete adherence defined as MMAS < 1. Logistic regression models were developed to assess the effects of self-perceived copay burden on adherence while adjusting for demographics, substance use, concomitant psychotropic medications, comorbidities, and health insurance. **RESULTS:** Of the 351 study respondents who met the criteria for analysis, 39% (n = 137) perceived experiencing burden from their medication copays. Adjusting for covariates, the effects of copay burden on general adherence approached but did not reach significance (p = 0.060). However, patients who experienced a copay burden were less than half as likely to have complete adherence [OR = 0.427; 95% CI: (0.257, 0.711); p = 0.001]. Effects of copay burden on the individual components of the MMAS varied. Patients with copay burden were more likely to forget to take medication [OR = 2.058; 95% CI: (1.270, 3.335); p = 0.003] and to discontinue medication when feeling worse [OR = 2.000; 95% CI: (1.140, 3.507); p = 0.016]. Being careless about taking medication and discontinuing medication when feeling better were not significantly affected by copay burden. **CONCLUSIONS:** Among patients with schizophrenia using SGAs, copay burden is associated with forgetting to take medication, discontinuing medication when feeling worse, and lesser likelihood of complete adherence. Less restrictive formularies that reduce copay burden for SGAs may have a positive effect on medication adherence among patients with schizophrenia.

PMH46

PREDICTORS OF DULOXETINE TREATMENT PERSISTENCE FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

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OBJECTIVES: Treatment of depression is often accompanied by discontinuation and switching of antidepressant medications. Information on factors predicting persistence (and avoidance of switching) would thus be of value to medical decision makers. We assess the impact of demographics, initial dose, prior medications, and comorbidities on duloxetine treatment persistence for patients with major depressive disorder (MDD) using retrospective claims data. **METHODS:** Using the PharMetrics Database, we studied individuals aged 18–64 who initiated duloxetine treatment between April 2005 and March 2006, had ≥1 prior MDD diagnosis, and had continuous insurance coverage 6 months before and 12 months after initiation. Persistence was defined as ≥3 months' continuous duloxetine treatment. Stepwise logistic regression and tree analyses of demographics, initial dose, prior medications, and comorbidities assessed predictors of persistence. Sensitivity analysis was done by analyzing factors associated with switching to venlafaxine XR or a selective serotonin reuptake inhibitor (SSRI) within a year of initiating duloxetine. **RESULTS:** Among 9,148 patients (74.1% female; mean age = 45.6, SD = 11.1) who initiated duloxetine treatment, 63.5% had persistence of duloxetine treatment for ≥3 months. Regression results showed the most significant factors for persistence to be initial dose of ≥60 mg QD (OR = 1.38), age group of 46–64 yrs (OR vs. age 18–25 yrs = 1.63), and venlafaxine XR/SSRI use in the prior 3 months (OR = 1.64) (all p-values < .001). Sensitivity analysis showed initial dose of <60 mg QD was associated with switching from duloxetine (OR = 1.22), although other factors showed differences from the persistence analysis. **CONCLUSIONS:** The results suggest that for MDD patients, initial dose, age group, and recent

venlafaxine XR/SSRI use predict persistence on duloxetine treatment. Sensitivity analysis on switching showed a consistent effect of initial dose.

PMH47

REASONS FOR DISCONTINUATION AND CONTINUATION OF ANTIPSYCHOTIC THERAPY FROM PATIENT AND CLINICIAN PERSPECTIVES

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OBJECTIVES: To assess the reasons for discontinuation and for continuation of antipsychotic medication in the treatment of schizophrenia from patient and clinician perspectives. **METHODS:** Two measures were developed to assess the Reasons for Antipsychotic Discontinuation/Continuation (RAD), one from patient's perspective (RAD-I), and the other from clinician's perspective (RAD-Q). These measures were administered to patients enrolled in a 12-week study of antipsychotic medication in the treatment of schizophrenia (N = 630). Reasons for discontinuation and reasons for continuation with the assigned antipsychotic during the study were assessed. Reported reasons were rated as being a primary reason, very important, somewhat important, or of minor importance. The top primary reasons for medication discontinuation and continuation were identified from patient and clinician perspectives, and level of concordance between patients' and clinicians' reasons was assessed. **RESULTS:** The top primary reasons for medication discontinuation differed from the top primary reasons for continuation on the medication, with a high level of concordance between patients' and clinicians' perspectives. The top three primary reasons for medication discontinuation were insufficient improvement or worsening of positive symptoms, medication-related adverse events, and insufficient improvement or worsening of mood symptoms. The top three primary reasons for medication continuation were improvement in positive symptoms, subjective perception of improvement, and improvement in level of functioning. **CONCLUSIONS:** Medication efficacy appears to be the core driver of medication continuation and discontinuation, especially with regard to positive symptoms. Reasons for medication discontinuation differ somewhat from reasons for continuation, with a high level of concordance between patients' and clinicians' perspectives.

PMH48

BURDEN OF ILLNESS OF DEPRESSION SYMPTOMS AMONG PATIENTS WITH TYPE 2 DIABETES MELLITUS

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OBJECTIVES: The purpose of this analysis is to quantify the additive burden associated with experiencing depression symptoms in patients with type-2 diabetes mellitus (T2DM). **METHODS:** Data were from the 2008 US National Health and Wellness Survey (NHWS), an annual cross-sectional survey of self-reported health care attitudes, behaviors, disease states, and outcomes of adults aged 18+. Analyses were limited to respondents self-reporting a diagnosis of T2DM. Depression symptoms were defined as an affirmative response in the past month to: bothered by feeling down, depressed or hopeless; or bothered by having little interest or pleasure in doing things. Outcomes included health care utilization in the past six months, work productivity as measured by the Work Productivity and Activity Impairment (WPAI) questionnaire, and SF-12v2 summary scores. Logistic and linear regression models were developed to assess independent effects of depression on outcomes, while adjusting for demographics and co-morbidity. **RESULTS:** Among patients with T2DM, 38% self-reported depression symptoms. Adjusting for demographics and co-morbidity, patients with depression symptoms were 1.7 (p < 0.001) times as likely to visit the emergency room, 1.6 (p < 0.001) times as likely to be hospitalized, and had 2.2 (p < 0.001) additional provider visits compared to T2DM patients without depression symptoms. Depression symptoms were also associated with 21.4% (p < 0.001) greater impairment in daily activities and a decrease in SF-12v2 physical and mental summary scores of 4.0 (p < 0.001) and 12.7 (p < 0.001) points, respectively. Among patients who were employed full-time, depression symptoms were associated with 4.3% (p < 0.001) greater missed work time, 15.2% (p < 0.001) greater lost productivity while working, and 13.4% (p < 0.001) greater overall work impairment. **CONCLUSIONS:** In patients with T2DM, depression symptoms were associated with significant burden on health care utilization, work productivity, and health-related quality of life. Proper treatment of both T2DM and co-morbid depression in this population may reduce humanistic and economic burden of disease.

PMH49

ASSESSMENT OF TYPE 2 DIABETES MELLITUS PATIENTS WITH AND WITHOUT SYMPTOMS OF ADHD: PATIENT CHARACTERISTICS AND RESOURCE UTILIZATION DATA FROM AN INTERNET-BASED SURVEY

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OBJECTIVES: Type 2 Diabetes Mellitus (T2DM) is an adult-onset, chronic, metabolic disorder that affects approximately 23.5 million adults in the United States and requires management with daily medications, blood glucose monitoring, regular HbA1c assessments, diet, and exercise. If T2DM patients also have difficulties with planning, working memory, and organization, their health problems may be compounded due to inappropriate management of their chronic health condition. The current study sought to estimate the prevalence of T2DM patients with the